



State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

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Centers for Medicare and Medicaid Services, Region IX
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

RESPONSE TO THE REQUEST FOR ADDITIONAL INFORMATION FOR STATE
PLAN AMENDMENT 13-038

Dear Ms. Nagle:

The Department of Health Care Services (DHCS) is submitting its response to the March 5, 2014, Request for Additional Information (RAI) for State Plan Amendment (SPA) 13-038. DHCS responses to the RAI and the Centers for Medicare and Medicaid Services (CMS) formal comments are included with this letter, as well as the following updated SPA pages, which include pages to correct the limitations on psychiatry services per our discussion with CMS:

- Limitations on Attachment 3.1-A/B, Page 10
- Limitations on Attachment 3.1-A/B, Page 10a
- Limitations on Attachment 3.1-A/B, Page 10a.2
- Supplement 2 to Attachment 3.1-A Page 1
- Supplement 3 to Attachment 3.1-A Page 3 and Page 3a
- Supplement 3 to Attachment 3.1-A Page 4 and Page 4a
- Supplement 3 to Attachment 3.1-A Page 6 and Page 6a
- Supplement 1 to Attachment 3.1-B Page 1
- Supplement 3 to Attachment 3.1-B Page 1 and Page 1a
- Supplement 3 to Attachment 3.1-B Page 2 and Page 2a
- Supplement 3 to Attachment 3.1-B Page 4 and Page 4a

Ms. Gloria Nagle
Page 2

In addition, as recommended by CMS, DHCS removed Residential Substance Use Disorder Treatment services from the following SPA pages:

- Limitations on Attachment 3.1-A/B, page 20a
- Supplement 2 to Attachment 3.1-A Page 1
- Supplement 3 to Attachment 3.1-A Page 3
- Supplement 3 to Attachment 3.1-A Page 4a
- Supplement 3 to Attachment 3.1-A Page 6a
- Supplement 1 to Attachment 3.1-B Page 1
- Supplement 3 to Attachment 3.1-B Page 1
- Supplement 3 to Attachment 3.1-B Page 2a
- Supplement 3 to Attachment 3.1-B Page 4a services

DHCS would like to thank your staff for the open dialogue, technical assistance, and helpful guidance during the SPA review process. If you have any questions regarding the information provided, please contact Ms. Laurie Weaver, Chief, Medi-Cal Benefits Division, at (916) 552-9619 or by e-mail at Laurie.Weaver@dhcs.ca.gov.

Sincerely

Original Signed by Toby Douglas

Director

Enclosures

cc: Donald A. Novo
Division of Medicaid and Children's Health Operations
San Francisco Regional Office
Centers for Medicare and Medicaid Services
90 Seventh Street, Suite 5-300(5W)
San Francisco, CA 94103

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:
13-038

2. STATE
California

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2014

5. TYPE OF PLAN MATERIAL (*Check One*):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.130

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 \$67,881,000
b. FFY 2015 \$90,508,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Limitations on Attachment 3.1-A/B page 10
Limitations on Attachment 3.1-A/B page 10a
Limitations on Attachment 3.1-A/B page 10a.1
Limitations on Attachment 3.1-A/B page 10a.2
Limitations on Attachment 3.1-A/B page 20a
Supplement 1 to Attachment 3.1-B page 1
Supplement 2 to Attachment 3.1-A page 1
Supplement 3 to Attachment 3.1-A page 3
Supplement 3 to Attachment 3.1-A page 3a
Supplement 3 to Attachment 3.1-A page 4
Supplement 3 to Attachment 3.1-A page 4a (new)
Supplement 3 to Attachment 3.1-A page 5
Supplement 3 to Attachment 3.1-A page 6
Supplement 3 to Attachment 3.1-A page 6a (new)
Supplement 3 to Attachment 3.1-B page 1
Supplement 3 to Attachment 3.1-B page 1a
Supplement 3 to Attachment 3.1-B page 2
Supplement 3 to Attachment 3.1-B page 2a (new)
Supplement 3 to Attachment 3.1-B page 3
Supplement 3 to Attachment 3.1-B page 4
Supplement 3 to Attachment 3.1-B page 4a (new)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (*If Applicable*):

Limitations on Attachment 3.1-A/B page 10
Limitations on Attachment 3.1-A/B page 10a
Limitations on Attachment 3.1-A/B page 10a.1
Limitations on Attachment 3.1-A/B page 10a.2
Limitations on Attachment 3.1-A/B page 20a
Supplement 1 to Attachment 3.1-B page 1
Supplement 2 to Attachment 3.1-A page 1
Supplement 3 to Attachment 3.1-A page 3
Supplement 3 to Attachment 3.1-A page 3a
Supplement 3 to Attachment 3.1-A page 4
Supplement 3 to Attachment 3.1-A page 5
Supplement 3 to Attachment 3.1-A page 6
Supplement 3 to Attachment 3.1-B page 1
Supplement 3 to Attachment 3.1-B page 1a
Supplement 3 to Attachment 3.1-B page 2
Supplement 3 to Attachment 3.1-B page 3
Supplement 3 to Attachment 3.1-B page 4

10. SUBJECT OF AMENDMENT:

Substance Use Disorder services expansion

11. GOVERNOR'S REVIEW (*Check One*):

GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:
Governor's Office does not wish to Review
State Plan Amendments

Original Signed by Toby Douglas

16. RETURN TO:

Department of Health Care Services
Nathaniel Emery
State Plan Coordinator
MS 4600
P.O. Box 997417
Sacramento, CA 95899-7417

14. TITLE:
Director, Department of Health Care Services

15. DATE SUBMITTED:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

1. Provider Enrollment

In previous correspondence, the state indicated it is considering additional statutory and regulatory changes to strengthen the certification criteria for Drug Medi-Cal (DMC) providers aimed at preventing fraud, waste and abuse. As an example, the state said it is developing more clearly defined quality requirements and performance measures for medical directors and staff. Please explain what these new requirements and measures are, and what other specific statutory and regulatory changes to DMC certification criteria the state is considering.

As the front end effort in preventing fraud, waste and abuse, the DHCS's Provider Enrollment Divisions is conducting a gap analysis between the existing DMC standards and the fee for service provider requirements and processes for certification/enrollment. PED will seek to make DMC requirements more in line with fee for service provider requirements, address areas lacking regulatory authority and revise the application and requirements to obtain detailed information necessary to ensure each provider is properly vetted. At this time, the gap analysis is under review and no final decisions have been made. However, some of the considerations include revising the application to gather more information to meet certain ACA requirements (42 CFR §455.416, 42 CFR §455.416 and 42 CFR §455.460) and requiring items such as partnership agreements, Articles of Incorporation for corporate entities, proof of licensure of Residential providers, Medi-Cal disclosure statement, provider agreement, etc.

In addition, the department is assessing options for regulatory changes such as, researching appropriate levels of physician to patient ratios to determine a standard for the DMC Program, defining medical necessity determination more clearly in the regulations and requiring physician/beneficiary contact in order to make that determination, requiring a beneficiary physical examination prior to admission, and clarifying documentation requirements. Any proposed regulatory changes will still need to be vetted through an extensive stakeholder and control agency review and approval process.

In regard to performance measures, the department has created data indicator reports (DIRs) to assess provider performance. The department works with counties through its county monitoring process to review and discuss the performance of the county's providers based on the DIRs. The DIRs reflect a combination of the indicators that research indicates leads to successful long term recovery or longer periods of recovery before relapse. Those indicators are: successful completion of treatment by completion of treatment plan goals; abstinence in the 30 days prior to discharge; a stay in treatment that is 90 days or longer; and, four or more social supports in the 30 days prior to discharge.

PED does not define quality requirements and performance measures for medical directors and staff and defers to Program (SUD P&T) for such non-enrollment considerations.

2. Supplement 2 to Attachment 3.1-A, Page 1- Extended Services for Pregnant Women

Rehabilitative services must meet the definition at 42 CFR 440.130, medical or remedial services ordered by a physician or other licensed practitioner, for the maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level. In our previous correspondence with the state, CMS requested that the state describe therapeutic interventions. While the state responded by defining therapeutic interventions as counseling services, including individual and group counseling, patient education, crisis intervention, and collateral services, we request that the state include those specific elements of the service in the state plan. The state can do so by adding the description on this page or the state may cross-walk this information by reference to information included in the rehabilitation section.

Also on this page, the state edited the bullets under item c. Residential Substance Use Disorder Treatment Services. However, CMS requests additional revisions. As noted above, the first bullet, "Therapeutic interventions" should contain the elements of the service (i.e., counseling, patient education, etc.). In addition, the rest of the bullet, starting with "addressing issues...." should be deleted as these services are unnecessary or not appropriately covered under Medicaid. For example, as we noted in our previous correspondence, the provision of cooperative childcare is not a Medicaid coverable service. In addition, we believe that parenting skills and education (second bullet) would be included as part of the counseling and patient education elements of therapeutic interventions, so there is no need to duplicate that information. Therefore, the second bullet should be deleted.

The state has included the additional revisions requested by CMS.

3. Supplement 3 to Attachment 3.1-A, Page 3 - Rehabilitation Services -13.d.5 SUD Treatment Services and Residential Substance Use Disorder Treatment, Page 4a

CMS requested that clarification of the state's medical necessary determination process be included in the state plan to assure that the state, not providers, is responsible for the medical necessity determination. The state provided a response but did not revise the plan language. Therefore, we request that the state include the additional language in the plan that is reflected in the aforementioned response. Specifically, the state should revise the first paragraph on page 3 and the first paragraph on page 4a, to accurately reflect the information provided in the state's response. For example:

Medically necessary rehabilitative services are provided, in accordance with an individualized Client Plan prescribed by a licensed physician, and approved and authorized according to the State of California requirements.

The state has included the additional language as requested.

4. Supplement 3 to Attachment 3.1-A- Narcotic Treatment Program Page 4

CMS requested that the state clarify whether the 200 minute monthly maximum on narcotic treatment counseling could be exceeded. The state indicated that the limit can be exceeded but that the provider would not be reimbursed for additional counseling above the 200 minute maximum. Because providers will not be reimbursed, this appears to be a hard limit on services. Therefore, CMS is requesting the following information related to the sufficiency of the services being provided:

The 200 minute monthly maximum on narcotic treatment counseling can be exceeded based upon medical necessity and the provider will be reimbursed for additional counseling above the 200 minute maximum. As a result, CMS indicates that the following sufficiency questions no longer require responses from the state.

1) What is the reason for this limitation?

a. If the reason is budgetary, please provide the assumptions used to support the savings, if not already provided.

b. If the reason for the limitation is duplication of services, abuse or inappropriate utilization, please provide the evidence that supports this reasoning. What other approaches/initiatives/processes have you tried or considered to address this matter?

2) Does the limitation apply to services performed through managed care contracts, fee-for-service (FFS) or both? If applied in managed care, indicate whether or not the capitation rates will be adjusted to reflect the change.

3) If the limit cannot be exceeded based on a determination of medical necessity:

a. How will those affected by the limitation obtain the medical services they need beyond the stated limits?

b. You have indicated that providers may furnish additional services but will not be reimbursed for those additional hours. Will beneficiaries be billed and expected to pay for any care that may not be covered? Or, instead is the provider or practitioner expected to absorb the costs of the provided services?

c. Is the beneficiary notified of their appeals rights per 42 CFR 431.206?

4) How will the limitation be tracked? Will both providers and beneficiaries be informed in advance so they know they have reached the limit? Please summarize the process.

5) How does the state implement the limit? Has the state been conducted a retrospective review of claims? If so, please describe the process/purpose for such review. How does this impact the provider/beneficiary if the claim is denied?

6) What is the clinical purpose of this benefit and will that purpose be achieved under this limit?

7) Based on this purpose indicated and using claims data within the last 12 months, what percentage of Medicaid beneficiaries would be fully served (i.e., receive all the services they require) under the new limit? Please provide this information for the following eligibility groups:

a) Aged, Blind and Disabled

i) Non-Dually Eligible Adults (for analyses of primary services for which Medicare would be primary payer)

ii) Dually Eligible b) Pregnant Women

c) Parents/Caretakers /Other Non-Disabled Adults

8) If the data requested above is not available, or is not relevant to demonstrating the sufficiency of the proposed limitation, please indicate support for this proposed scope of services through clinical literature or evidence-based practice guidelines, or describe the consultation with your provider community or others that resulted in an assurance that this proposed scope of services has meaningful clinical merit to achieve its intended purpose.

9) Are there any exemptions to the proposed limitations? If so, how is this exemption(s) determined to be appropriate?

5. Supplement 3 to Attachment 3.1-A- Residential Substance Use Disorder Treatment, Page 4a CMS requested that the state revise this page to remove "Care Coordination Services" as they should be included in other service categories in the plan. The state has revised the page to remove the reference to Care Coordination and has modified the list of components of residential SUD treatment services as requested. However, because these are 24-hour a day residential services, CMS request that the state clarify the minimum amount of services that would be received for each of these components. For example, does an eligible beneficiary receive, at a minimum, one hour per day of counseling, or, at a minimum, four hours per month of collateral services?

The state will provide the minimum amount of services for the service components.

6. Supplement 3 to Attachment 3.1-A, page 6- IMD Assurance

In Supplement 3 to Attachment 3.1-A, page 6 and Attachment 3.1-B, Page 4, the state provides assurances that Residential Substance Use Disorder Treatment Services and Perinatal Residential Substance Use Disorder Services are not provided in facilities that are Institutions for Mental Diseases. Based on conversations with the state on 1/14/14, CMS confirmed that an IMD is an institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases (including substance use disorder). The regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases (including substance use disorder). The overall character and the number of beds in the facility are key factors in determining IMD status. We request the state reconfirm that claims have not been made for, and reimbursement will not be sought for, any services provided to individuals residing in residential treatment centers that are IMDs.

Based upon discussions with CMS beginning on January 14, 2014, the state deleted residential treatment services from the Alternative Benefit Plan and SPA 13-038, in recognition of the characteristics of Institutions for Mental Diseases as described by CMS and in regulations. The state and CMS continue to discuss options for the provision of comprehensive substance use disorder services, including residential treatment services, via an organized delivery system approved through an 1115 Waiver.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5a. Physician's Services (continued)	<p>Procedures generally considered to be elective must meet criteria established by the Director.</p> <p>Orthoptics and pleoptics (eye exercises for the purpose of treating focusing problems using both eyes) are not covered. (Orthoptics relate to problems with the muscles that move the eyes, while pleoptics relate to problems with the retina.)</p> <p>Psychology, physical therapy, occupational therapy, speech therapy, audiology, optometry, and podiatry when performed by a physician are considered to be physician services for purposes of program coverage.</p>	<p>Outpatient medical procedures such as hyperbaric O² therapy, psoriasis day care, apheresis, cardiac, catheterization, and selected surgical procedures (generally considered to be elective) are subject to prior authorization. Prior authorization is required for the correction of cosmetic defects. Inhalation therapy when not personally rendered by a physician requires prior authorization. All sterilizations require informed consent.</p> <p>Prior authorization is required for the following: Injections for allergy desensitization, hyposensitization, or immunotherapy by injection of an antigen to stimulate production of protective antibodies in excess of 8 in any 120-day period.</p>

*Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5a. Physician's Services (continued)	<p>Procedures generally considered to be elective must meet criteria established by the Director.</p> <p>Orthoptics and pleoptics (eye exercises for the purpose of treating focusing problems using both eyes) are not covered. (Orthoptics relate to problems with the muscles that move the eyes, while pleoptics relate to problems with the retina.)</p> <p>Psychology, physical therapy, occupational therapy, speech therapy, audiology, optometry, and podiatry when performed by a physician are considered to be physician services for purposes of program coverage.</p>	<p>Outpatient medical procedures such as hyperbaric O² therapy, psoriasis day care, apheresis, cardiac, catheterization, and selected surgical procedures (generally considered to be elective) are subject to prior authorization. Prior authorization is required for the correction of cosmetic defects. Inhalation therapy when not personally rendered by a physician requires prior authorization. All sterilizations require informed consent.</p> <p>Prior authorization is required for the following: Injections for allergy desensitization, hyposensitization, or immunotherapy by injection of an antigen to stimulate production of protective antibodies in excess of 8 in any 120-day period.</p>

*Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5a. Physician's Services (continued)	Shall include services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist. Routine eye examinations with refraction are provided when medically necessary.	

* Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

TN No. 13-038
Supersedes
TN No. 06-009

Approval Date: _____

Effective Date: 1/1/14

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5a. Physician's Services (continued)	Shall include services of the type which an optometrist is legally authorized to perform, and shall be reimbursed whether furnished by a physician or an optometrist. Routine eye examinations with refraction are provided when medically necessary.	

* Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

TN No. 13-038
Supersedes
TN No. 06-009

Approval Date: _____

Effective Date: 1/1/14

STATE PLAN CHART

(Note: This chart is an overview only.)

TYPES OF SERVICE	PROGRAM COVERAGE**	AUTHORIZATION AND OTHER REQUIREMENTS*
5a Physician's Services (continued)	Outpatient heroin or other opioid detoxification services are administered or prescribed by a physician, or medical professional under the supervision of a physician.	Outpatient heroin or other opioid detoxification services require prior authorization and are limited to 21 consecutive calendar days of treatment, regardless if treatment is received each day. When medically necessary, additional 21-day treatments are covered after 28 days have elapsed from the completion of a preceding course of treatment. During the 28 day lapse, beneficiaries can receive maintenance treatment. Services are covered for beneficiaries under the age of 21 years when medically necessary. The narcotic drug methadone can only be rendered in state licensed Narcotic Treatment Programs, as required by federal and state law. Other narcotic and non-narcotic drugs permitted by federal law may be used for outpatient heroin or other opioid detoxification services at any outpatient clinic or physician office setting where the medical staff has appropriate state and federal certifications for treatment of opioid dependence outside of Narcotic Treatment Programs. Additional charges may be billed for services medically necessary to diagnose and treat disease(s) which the physician believes are concurrent with, but not part of, outpatient heroin or other opioid detoxification services. Services are covered to the extent that they are permitted by federal law.

*Prior Authorization is not required for emergency services.

**Coverage is limited to medically necessary services

TN No. 13-038
Supersedes
TN No. 11-037b

Approval Date: _____

Effective Date: 1/1/2014

STATE PLAN CHART

(Note: This chart is an overview only.)

TYPES OF SERVICE	PROGRAM COVERAGE**	AUTHORIZATION AND OTHER REQUIREMENTS*
5a Physician's Services (continued)	Outpatient heroin or other opioid detoxification services are administered or prescribed by a physician, or medical professional under the supervision of a physician.	Outpatient heroin or other opioid detoxification services require prior authorization and are limited to 21 consecutive calendar days of treatment, regardless if treatment is received each day. When medically necessary, additional 21-day treatments are covered after 28 days have elapsed from the completion of a preceding course of treatment. During the 28 day lapse, beneficiaries can receive maintenance treatment. Services are covered for beneficiaries under the age of 21 years when medically necessary. The narcotic drug methadone can only be rendered in state licensed Narcotic Treatment Programs, as required by federal and state law. Other narcotic and non-narcotic drugs permitted by federal law may be used for outpatient heroin or other opioid detoxification services at any outpatient clinic or physician office setting where the medical staff has appropriate state and federal certifications for treatment of opioid dependence outside of Narcotic Treatment Programs. Additional charges may be billed for services medically necessary to diagnose and treat disease(s) which the physician believes are concurrent with, but not part of, outpatient heroin or other opioid detoxification services. Services are covered to the extent that they are permitted by federal law.

*Prior Authorization is not required for emergency services.

**Coverage is limited to medically necessary services

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5b. Medical and surgical services furnished by a dentist, to the extent mandated by 42 U.S.C Section 1396(a)(5)(B), are covered.	Pursuant to 42 CFR Section 440.50(b), medical and surgical services of a dentist means medical or surgical services furnished by a physician or a doctore of medicine or dental surgery.	Medical and surgical services furnished by a dentist, as described, administered, through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI). Subject to state supervision, discretion, and oversight, and applicatble federal and state statutes, regulations, and manual of criteria and utilization controls, the Dental FI approves and provides payment for the above services performed by an enrolled dental provider. Prior authorization of a defined subset of the above services is required.

* Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

TN No. 13-038
Supersedes
TN No. 11-017

Approval Date: _____

Effective Date: 1/1/14

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
5b. Medical and surgical services furnished by a dentist, to the extent mandated by 42 U.S.C Section 1396(a)(5)(B), are covered.	Pursuant to 42 CFR Section 440.50(b), medical and surgical services of a dentist means medical or surgical services furnished by a physician or a doctor of medicine or dental surgery.	Medical and surgical services furnished by a dentist, as described, administered, through a contract with the Medi-Cal Dental Fiscal Intermediary (Dental FI). Subject to state supervision, discretion, and oversight, and applicable federal and state statutes, regulations, and manual of criteria and utilization controls, the Dental FI approves and provides payment for the above services performed by an enrolled dental provider. Prior authorization of a defined subset of the above services is required.

* Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

TN No. 13-038
Supersedes
TN No. 11-017

Approval Date: _____

Effective Date: 1/1/14

(Note: This chart is an overview only.)

TYPE OF SERVICE***	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.5 Substance Use Disorder Treatment Services (continued)	Outpatient Drug Free Treatment Services (see Supplement 3 to Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required. In cases where additional EPSDT services are needed for individuals under 21, these services are available subject to prior authorization. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	Intensive Outpatient Treatment Services (see Supplement 3 to Attachment 3.1-A for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	Perinatal Residential Substance Use Disorder Services (see Supplemental 3 to Attachment 3.1-A for program coverage and details)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims. The cost of room and board are not reimbursable DMC services.
	Substance Use Disorder Treatment Services provided to Pregnant and Postpartum Women (see Supplemental 3 to Attachment 3.1-A for program coverage and details)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.

*Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

***Outpatient services are pursuant to 42 CFR 440.130.

(Note: This chart is an overview only.)

TYPE OF SERVICE***	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
13.d.5 Substance Use Disorder Treatment Services (continued)	Outpatient Drug Free Treatment Services (see Supplement 3 To Attachment 3.1-B for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required. In cases where additional EPSDT services are needed for individuals under 21, these services are available subject to prior authorization. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	Intensive Outpatient Treatment services (see Supplement 3 To Attachment 3.1-B for program coverage and details under 13.d.5 Substance Use Disorder Treatment Services)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.
	Perinatal Residential Substance Use Disorder Services (see Supplemental 3 to Attachment 3.1-B for program coverage and details)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims. The cost of room and board are not reimbursable DMC services.
	Substance Use Disorder Treatment Services Provided to Pregnant and Postpartum Women (see Supplemental 3 to Attachment 3.1-B for program coverage and details)	Prior authorization is not required. Post-service periodic reviews include an evaluation of medical necessity, frequency of services, appropriateness and quality of care, and examination of clinical charts and reimbursement claims.

*Prior authorization is not required for emergency services.

**Coverage is limited to medically necessary services.

***Outpatient services are pursuant to 42 CFR 440.130.

State/Territory: California

20. Extended Services for Pregnant Women

a. Pregnancy-related and postpartum services for 60 days after pregnancy ends.

Provided: Pregnancy-related and postpartum services include all antepartum (prenatal) care, care during labor and delivery, postpartum care, and family planning. Pregnancy-related services include all care normally provided during pregnancy (examinations, routine urine analyses, evaluations, counseling, and treatment) and labor and delivery (initial and ongoing assessment of maternal and fetal well-being and progress of labor, management of analgesia and local or pudendal anesthesia, vaginal delivery with or without episiotomy, initial assessment and, when necessary, resuscitation of the newborn infant). Postpartum care includes those services (hospital and scheduled office visits during the puerperium, assessment of uterine involution and, as appropriate, contraceptive counseling) provided for 60 days after pregnancy ends. Family planning services include contraceptive counseling and tubal ligation.

Pregnancy-related and postpartum services may also include outpatient alcohol and other drug treatment services that ameliorate conditions that complicate pregnancy when prescribed by a physician as medically necessary. These services include women-specific treatment and recovery services.

See Supplement 3 to Attachment 3.1-B page 1 for a complete description of services available to all beneficiaries

b. Services for any other medical conditions that may complicate pregnancy.

Provided: Treatment for obstetrical complications (including preexisting or developing maternal or fetal conditions) which create a high-risk pregnancy and which may or may not be pregnancy-related is also covered.

State/Territory: California

20. Extended Services for Pregnant Women

a. Pregnancy-related and postpartum services for 60 days after pregnancy ends.

Provided: Pregnancy-related and postpartum services include all antepartum (prenatal) care, care during labor and delivery, postpartum care, and family planning. Pregnancy –related services include all care normally provided and during pregnancy (examinations, routine urine analyses, evaluations, counseling, and treatment) and labor and delivery (initial and ongoing assessment of maternal and fetal well-being and progress of labor, management of analgesia and local or pudendal anesthesia, vaginal delivery with or without episiotomy, initial assessment and, when necessary, resuscitation of the newborn infant). Postpartum care includes those services (hospital and scheduled office visits during the puerperium, assessment of uterine involution and, as appropriate, contraceptive counseling) provided 60 days after pregnancy ends. Family planning services include contraceptive counseling and tubal ligation.

Pregnancy-related and postpartum services may also include outpatient alcohol and other drug treatment services that ameliorate conditions that complicate pregnancy when prescribed by a physician as medically necessary. These services include women-specific treatment and recovery services.

See Supplement 3 to Attachment 3.1-A page 3 for a complete description of services available to all beneficiaries

b. Services for any other medical conditions that may complicate pregnancy.

Provided: Treatment for obstetrical complications (including preexisting or developing maternal or fetal conditions) which create a high-risk pregnancy and which may or may not be pregnancy-related is also covered.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO THE CATEGORICALLY NEEDY

LIMITATION ON SERVICES

13.d.5 Substance Use Disorder Treatment Services

Substance use disorder treatment services are provided to stabilize and rehabilitate Medi-Cal beneficiaries who have been recommended by physicians or other licensed practitioners of the healing arts, within the scope of their practices, to receive treatment for a substance-related disorder. Substance use disorder treatment services are provided by DMC certified substance use disorder treatment facilities, DMC certified satellite sites, or DMC certified perinatal residential substance use disorder programs and are based on medical necessity. Medically necessary rehabilitative services are provided in accordance with an individualized client plan prescribed by a licensed physician, and approved and authorized according to the State of California requirements, excluding crisis services for which a client plan is not required. Services include:

- Intensive Outpatient Treatment; these services are pursuant to 42 CFR 440.130
- Naltrexone Treatment
- Narcotic Treatment Program
- Outpatient Drug Free Treatment
- Perinatal Residential Substance Use Disorder Services

The intake assessment and treatment plan are standard for all DMC treatment modalities (see SUD Services Chart for service definitions).

Intensive Outpatient Treatment counseling services are provided to patients a minimum of three hours per day, three days a week, and are available to all patients for whom it has been determined by a physician to be medically necessary.

The components of Intensive Outpatient Treatment are:

- Intake
- Individual and Group Counseling
- Patient Education
- Medication Services
- Collateral Services
- Crisis Intervention Services
- Treatment Planning and Discharge Services

Naltrexone is a medication provided as an outpatient treatment service directed at serving detoxified opioid addicts and is covered under Drug Medi-Cal in oral form when prescribed by a physician as medically necessary. Oral Naltrexone for the treatment of alcohol dependence and injectable Naltrexone for the treatment of alcohol or opioid dependence is available through a Medi-Cal Treatment Authorization Request (TAR). Other narcotic and non-narcotic drugs for the treatment of opioid dependence are available through Medi-Cal when medically necessary (see Limitations on Attachment 3.1-A page 10a.1 for additional information). A patient must receive at least two face-to-face counseling sessions with a therapist or counselor every 30-day period. The intake assessment to admit a patient into the program is the same as for the Narcotic Treatment Program.

The components of Naltrexone Treatment Services are:

- Intake
- Individual and Group Counseling
- Patient Education
- Medication Services
- Collateral Services
- Crisis Intervention Services
- Treatment Planning and Discharge Services

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Narcotic Treatment Program: This outpatient program uses methadone (or levoalphacetylmethadol (LAAM) if available and prescribed) as a narcotic replacement drug-when ordered by a physician as medically necessary to alleviate the symptoms of withdrawal from opioids. A patient must receive a minimum of fifty minutes of face-to-face counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.

The components of the Narcotic Treatment Program are:

- Intake
- Individual and Group Counseling
- Patient Education
- Medical Psychotherapy
- Medication Services
- Collateral Services
- Crisis Intervention Services
- Treatment Planning and Discharge Services

Outpatient Drug Free (ODF) Treatment Services to stabilize and rehabilitate patients who have a substance use disorder diagnosis are covered under DMC when prescribed by a physician as medically necessary.

The components of Outpatient Drug Free Treatment Services are:

- Intake
- Individual and Group Counseling
- Patient Education
- Medication Services
- Collateral Services
- Crisis Intervention Services
- Treatment Planning and Discharge Services

Individual counseling is provided only for the purposes of intake, crisis intervention, collateral services, and treatment and discharge planning. Each ODF participant is to receive at least two group face-to-face counseling sessions every thirty days (4-10 participants) focused on short-term personal, family, job/school and other problems and their relationship to substance use. Reimbursable group sessions may last up to 90 minutes.

Perinatal Residential Substance Use Disorder Treatment is a non-institutional, non-medical, residential program which provides rehabilitation services to pregnant and postpartum women with a substance use disorder diagnoses. These services include women-specific treatment and recovery services. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Services are provided in a 24-hour structured environment and covered under the Drug Medi-Cal program when medically necessary. Medically necessary rehabilitative services are provided in accordance with an individualized client plan prescribed by a licensed physician, and approved and authorized according to the State of California requirements. The cost of room and board are not reimbursable under the Medi-Cal program.

The components of Perinatal Residential Substance Use Disorder Treatment are:

- Intake, once per admission
- Individual and Group Counseling, a minimum of two sessions per 30 day period
- Patient Education, varies according to the needs of the beneficiary
- Collateral Services, as needed
- Crisis Intervention Services, as needed
- Treatment Planning, occurs upon admission and every 90 days thereafter
- Discharge Services, once per admission

Services shall include:

- Provision of or arrangement for transportation to and from medically necessary treatment.
- Safeguarding Medication: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Provider Qualifications

Substance use disorder services are provided at qualified and DMC certified substance use disorder treatment clinics, their DMC certified satellite sites, and DMC certified perinatal residential substance use disorder programs that agree to abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services, and that sign a provider agreement with a county or the State.

Services are provided by a qualified substance use disorder treatment professional functioning within the scope of his/her practice as defined in the California Code of Regulations, Title 9, Section 13005(a)(4)(A-F).

A substance use disorder treatment professional can qualify to provide alcohol and other drug (AOD) counseling in any DMC certified program in one of the following ways:

- As a registrant in a certifying organization that is accredited with the National Commission for Certifying Agencies (NCCA); the registrant must be enrolled in a counseling certification program and complete counseling certification requirements within five years. **Or**;
- As an AOD counselor, certified by an organization that is accredited with the NCCA; qualifications to become certified as an AOD counselor are (Title 9, Section 13040):
 - 155 hours of formal classroom AOD education to include:
 - Additional Counseling Competencies curriculum and Technical Assistance Publication Series 21 (TAP 21), published by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment
 - Provisions of services to special populations
 - Ethics
 - Communicable diseases
 - Prevention of sexual harassment
 - 160 hours of supervised AOD training based on the curriculum in TAP 21
 - 2,080 additional documented hours of paid or unpaid work experience providing counseling services in an AOD program
 - Obtain a score of at least 70 percent on a written or oral examination

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

- Sign a statement documenting whether his/her prior certification as an AOD counselor has ever been revoked; and
- Sign an agreement to abide by the code of conduct. **Or;**
- One of the following:
 - A physician licensed by the Medical Board of California
 - A psychologist licensed by the Board of Psychology
 - A clinical social worker or marriage and family therapist licensed by the California Board of Behavioral Sciences; or,
 - An intern registered with the California Board of Psychology or the California Board of Behavioral Sciences

Assurances

The State assures that substance use disorder treatment services shall be available to children and youth found to be eligible under the provisions of Social Security Act section 1905(r)(5).

The State assures that the Single State Agency shall not delegate to any other State Agency the authority and responsibilities described in 42 CFR section 431.10(e).

The State assures that all Medicaid program requirements regarding free choice of providers as defined in 42 CFR 431.51 shall be adhered to.

The State assures that Perinatal Residential Substance Use Disorder Services are not provided in facilities that are Institutes for Mental Diseases.

The provider qualifications for DMC benefits are the same across all the service modalities. See chart on page 6a of Supplement 3 to Attachment 3.1-A.

Service Component	Intake ³		Group Counseling		Individual Counseling		Patient Education		Medical Psychotherapy	Medication Services	Transportation Services	Collateral Services		Crisis Intervention Services		Treatment Planning*		Discharge Services*	
	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²
	Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. Approval of a treatment plan by a physician licensed in the State of California. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory	Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder which includes exploration of relevant mental, emotional, psychological and behavioral problems that may be contributing to the substance use disorder. This may also include health questionnaires.	Face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time, focusing on the needs of the individuals served. For outpatient drug free treatment services and narcotic treatment programs, group counseling shall be conducted with no less than four and no more than 10 clients at the same time, only one of whom needs to be a Medi-Cal beneficiary.	Face-to-face contacts between a beneficiary and a therapist or counselor. Telephone contacts, home visits, and hospital visits shall not qualify as Medi-Cal reimbursable units of service.	A learning experience using a combination of methods such as teaching, counseling, and behavior modification techniques which influence patients' knowledge and health and illness behavior.	Type of counseling service consisting of a face-to-face discussion conducted by the medical director of the Narcotic Treatment Program on a one-to-one basis with the patient.	The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within the scope of their practice or licensure.	Provision of or arrangement for transportation to and from medically necessary treatment.	Face-to-face sessions with therapists or counselors and significant persons in the life of a beneficiary, focusing on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.	Face-to-face contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation.	The provider shall prepare an individualized written treatment plan, based on information obtained in intake and assessment process. The treatment plan includes: problems to be addressed, goals to be reached which address each problem, action steps which will be taken by the provider and/or beneficiary to accomplish identified goals, target dates for accomplishment of action steps and goals, and a description of services, including the type of counseling to be provided and the frequency thereof. The treatment plan may also include medical direction.	The process to prepare a person for the post treatment return or reentry into the community, and the linkage of the individual to essential community treatment, housing and human services.							
Provider Type	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²
Intensive Outpatient Treatment	X		X		X		X			X	PNO	X		X		X		X	
Naltrexone Treatment	X		X		X		X			X		X		X		X		X	
Narcotic Treatment Program	X		X		X		X		X	X	PNO	X		X		X		X	
Outpatient Drug Free Treatment	X		X		X		X			X	PNO	X		X		X		X	
Perinatal Residential Substance Use Disorder Services	X		X		X		X			S	X	X		X		X		X	

¹ Licensed providers must meet the following qualifications: MD, PA, NP, RN, Psy. D, LCSW, MFT or Intern registered by Board of Psychology or Behavioral Science Board and supervised by a mental health professional.

² Certified providers must meet the following qualifications: Counselors or registrants certified by an organization who will have 155 hours of formal Education; 160 hours of supervised AOD training; 2,080 hours of work experience in AOD counseling; obtain at least 70% score on a written or oral examination approved by the certifying organization and complete 40 hours of continuing education every two years in order to retain certification.

³ The process of admitting a beneficiary into a Substance Use Disorder Treatment Program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; the assessment of treatment needs to provide medically necessary services; and assistance with accessing community and human services networks. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.

* Certified personnel may assist with some aspects of this service, however, a licensed provider is responsible for this service component.

PNO - Perinatal Outpatient SUD Services

S - Safeguarding Medication; assistance with resident's self-administration of medication.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES
PROVIDED TO MEDICALLY NEEDY GROUP(S)

LIMITATION ON SERVICES

13.d.5 Substance Use Disorder Treatment Services

Substance use disorder treatment services are provided to stabilize and rehabilitate Medi-Cal beneficiaries who have been recommended by physicians or other licensed practitioners of the healing arts, within the scope of their practices, to receive treatment for a substance-related disorder. Substance use disorder treatment services are provided by DMC certified substance use disorder treatment facilities, their DMC certified satellite sites, or DMC certified perinatal residential substance use disorder programs and are based on medical necessity. Medically necessary rehabilitative services are provided in accordance with an individualized client plan prescribed by a licensed physician, and approved and authorized according to the State of California requirements, excluding crisis services for which a client plan is not required. Services include:

- Intensive Outpatient Treatment; these services are pursuant to 42 CFR 440.130
- Naltrexone Treatment
- Narcotic Treatment Program
- Outpatient Drug Free Treatment
- Perinatal Residential Substance Use Disorder Services

The intake assessment and treatment plan are standard for all DMC treatment modalities (see SUD Services Chart for service definitions).

Intensive Outpatient Treatment counseling services are provided to patients a minimum of three hours per day, three days a week, and are available to all patients for whom it has been determined by a physician to be medically necessary.

The components of Intensive Outpatient Treatment are:

- Intake
- Individual and Group Counseling
- Patient Education
- Medication Services
- Collateral Services
- Crisis Intervention Services
- Treatment Planning and Discharge Services

Naltrexone is a medication provided as an outpatient treatment service directed at serving detoxified opioid addicts and is covered under Drug Medi-Cal in oral form when prescribed by a physician as medically necessary. Oral Naltrexone for the treatment of alcohol dependence and injectable Naltrexone for the treatment of alcohol or opioid dependence is available through a Medi-Cal Treatment Authorization Request (TAR). Other narcotic and non-narcotic drugs for the treatment of opioid dependence are available through Medi-Cal when medically necessary (see Limitations on Attachment 3.1-B page 10a.1 for additional information). A patient must receive at least two face-to-face counseling sessions with a therapist or counselor every 30-day period. The intake assessment to admit a patient into the program is the same as for the Narcotic Treatment Program.

The components of Naltrexone Treatment Services are:

- Intake
- Individual and Group Counseling
- Patient Education
- Medication Services
- Collateral Services
- Crisis Intervention Services
- Treatment Planning and Discharge Services

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO MEDICALLY NEEDY GROUP(S)

Narcotic Treatment Program: This outpatient program uses methadone (or levoalphacetylmethadol (LAAM) if available and prescribed) as a narcotic replacement drug-when ordered by a physician as medically necessary to alleviate the symptoms of withdrawal from opioids. A patient must receive a minimum of fifty minutes of face-to-face counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.

The components of the Narcotic Treatment Program are:

- Intake
- Individual and Group Counseling
- Patient Education
- Medical Psychotherapy
- Medication Services
- Collateral Services
- Crisis Intervention
- Treatment Planning and Discharge Services

Outpatient Drug Free (ODF) Treatment Services to stabilize and rehabilitate patients who have a substance use disorder diagnosis are covered under DMC when prescribed by a physician as medically necessary.

The components of Outpatient Drug Free Treatment Services are:

- Intake
- Individual and Group Counseling
- Patient Education
- Medication Services
- Collateral Services
- Crisis Intervention
- Treatment Planning and Discharge Services

Individual counseling is provided only for the purposes of intake, crisis intervention, collateral services, and treatment and discharge planning. Each ODF participant is to receive at least two group face-to-face counseling sessions every thirty days (4-10 participants) focused on short-term personal, family, job/school and other problems and their relationship to substance use. Reimbursable group sessions may last up to 90 minutes.

Perinatal Residential Substance Use Disorder Treatment is a non-institutional, non-medical, residential program which provides rehabilitation services to pregnant and postpartum women with a substance use disorder diagnosis. These services include women-specific treatment and recovery services. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Services are provided in a 24-hour structured environment and covered under the Drug Medi-Cal program when medically necessary. Medically necessary rehabilitative services are provided in accordance with an individualized client plan prescribed by a licensed physician, and approved and authorized according to the State of California requirements. The cost of room and board are not reimbursable under the Medi-Cal program.

The components of Perinatal Residential Substance Use Disorder Treatment are:

- Intake, once per admission
- Individual and Group Counseling, a minimum of two sessions per 30 day period
- Patient Education, varies according to the needs of the beneficiary
- Collateral Services, as needed
- Crisis Intervention Services, as needed
- Treatment Planning, occurs upon admission and every 90 days thereafter
- Discharge Services, once per admission

Services shall include:

- Provision of or arrangement for transportation to and from medically necessary treatment.
- Safeguarding Medication: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

Provider Qualifications

Substance use disorder services are provided at qualified and DMC certified substance use disorder treatment clinics, their DMC certified satellite sites, ~~or~~ and DMC certified perinatal residential substance use disorder programs that agree to abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services, and that sign a provider agreement with a county or the State.

Services are provided by a qualified substance use disorder treatment professional functioning within the scope of his/her practice as defined in the California Code of Regulations, Title 9, Section 13005(a)(4)(A-F).

A substance use disorder treatment professional can qualify to provide alcohol and other drug (AOD) counseling in any DMC certified program in **one** of the following ways:

- As a registrant in a certifying organization that is accredited with the National Commission for Certifying Agencies (NCCA); the registrant must be enrolled in a counseling certification program and complete counseling certification requirements within five years. **Or**;
- As an AOD counselor, certified by an organization that is accredited with the NCCA; qualifications to become certified as an AOD counselor are (Title 9, Section 13040):
 - 155 hours of formal classroom AOD education to include:
 - Addiction Counseling Competencies curriculum and Technical Assistance Publication Series 21 (TAP 21), published by the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment
 - Provisions of services to special populations
 - Ethics
 - Communicable diseases
 - Prevention of sexual harassment
 - 160 hours of supervised AOD training based on the curriculum in TAP 21
 - 2,080 additional documented hours of paid or unpaid work experience providing counseling services in an AOD program
 - Obtain a score of at least 70 percent on a written or oral examination

State/Territory: California

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO MEDICALLY NEEDY GROUP(S)

- Sign a statement documenting whether his/her prior certification as an AOD counselor has ever been revoked; and
- Sign an agreement to abide by the code of conduct. **Or;**
- One of the following:
 - A physician licensed by the Medical Board of California
 - A psychologist licensed by the Board of Psychology
 - A clinical social worker or marriage and family therapist licensed by the California Board of Behavioral Sciences; or,
 - An intern registered with the California Board of Psychology or the California Board of Behavioral Sciences

Assurances

The State assures that substance use disorder treatment services shall be available to children and youth found to be eligible under the provisions of Social Security Act section 1905(r)(5).

The State assures that the Single State Agency shall not delegate to any other State Agency the authority and responsibilities described in 42 CFR section 431.10(e).

The State assures that all Medicaid program requirements regarding free choice of providers as defined in 42 CFR 431.51 shall be adhered to.

The State assures that Perinatal Residential Substance Use Disorder Services are not provided in facilities that are Institutes for Mental Diseases.

The provider qualifications for DMC benefits are the same across all the service modalities. See chart on page 4a of Supplement 3 to Attachment 3.1-B.

Service Component	Intake ³		Group Counseling		Individual Counseling		Patient Education		Medical Psychotherapy	Medication Services	Transportation Services	Collateral Services		Crisis Intervention Services		Treatment Planning*		Discharge Services*	
	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²
	Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. Approval of a treatment plan by a physician licensed in the State of California. This may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for treatment and evaluation conducted by staff lawfully authorized to provide such services and/or order laboratory	Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder which includes exploration of relevant mental, emotional, psychological and behavioral problems that may be contributing to the substance use disorder. This may also include health questionnaires.	Face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time, focusing on the needs of the individuals served. For outpatient drug free treatment services and narcotic treatment programs, group counseling shall be conducted with no less than four and no more than 10 clients at the same time, only one of whom needs to be a Medi-Cal beneficiary.	Face-to-face contacts between a beneficiary and a therapist or counselor. Telephone contacts, home visits, and hospital visits shall not qualify as Medi-Cal reimbursable units of service.	A learning experience using a combination of methods such as teaching, counseling, and behavior modification techniques which influence patients' knowledge and health and illness behavior.	Type of counseling service consisting of a face-to-face discussion conducted by the medical director of the Narcotic Treatment Program on a one-to-one basis with the patient.	The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within the scope of their practice or licensure.	Provision of or arrangement for transportation to and from medically necessary treatment.	Face-to-face sessions with therapists or counselors and significant persons in the life of a beneficiary, focusing on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.	Face-to-face contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation.	The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan includes: problems to be addressed, goals to be reached which address each problem, action steps which will be taken by the provider and/or beneficiary to accomplish identified goals, target dates for accomplishment of action steps and goals, and a description of services, including the type of counseling to be provided and the frequency thereof. The treatment plan may also include medical	The process to prepare a person for the post treatment return or reentry into the community, and the linkage of the individual to essential community treatment, housing and human services.							
Provider Type	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²	L ¹	C ²
Intensive Outpatient Treatment	X		X		X		X			X	PNO	X		X		X		X	
Naltrexone Treatment	X		X		X		X			X		X		X		X		X	
Narcotic Treatment Program	X		X		X		X		X	X	PNO	X		X		X		X	
Outpatient Drug Free Treatment	X		X		X		X			X	PNO	X		X		X		X	
Perinatal Residential Substance Use Disorder Services	X		X		X		X			S	X	X		X		X		X	

¹ Licensed providers must meet the following qualifications: MD, PA, NP, RN, Psy. D, LCSW, MFT or Intern registered by Board of Psychology or Behavioral Science Board and supervised by a mental health professional.

² Certified providers must meet the following qualifications: Counselors or registrants certified by an organization who will have 155 hours of formal Education; 160 hours of supervised AOD training; 2,080 hours of work experience in AOD counseling; obtain at least 70% score on a written or oral examination approved by the certifying organization and complete 40 hours of continuing education every two years in order to retain certification.

³ The process of admitting a beneficiary into a Substance Use Disorder Treatment Program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; the assessment of treatment needs to provide medically necessary services; and assistance with accessing community and human services networks. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.

* Certified personnel may assist with some aspects of this service, however, a licensed provider is responsible for this service component.

PNO - Perinatal Outpatient SUD Services

S - Safeguarding Medication; assistance with resident's self-administration of medication